Deputy sheriff plans

King County
Benefits, Payroll and Retirement Operations

As a deputy sheriff, you have some new plans in your 2009 benefits package: a new medical plan and a new vision plan. If you have questions about your benefits, contact Benefits, Payroll and Retirement Operations at 206-684-1556 or kc.benefits@kingcounty.gov.

Medical plans

Your medical plans include the new Deputy Sheriff Plan and Group Health. Unlike the previous PacifiCare and Regence plans, the Deputy Sheriff Plan does not cover vision. And, even though Group Health provides some vision coverage, your new benefit package includes a separate vision plan (see "Vision Plan" on page 12).

The following two tables summarize the features and covered expenses of the two medical plans for 2009. For both medical plans, there are gold and silver levels of out-of-pocket expenses – the gold level has the lowest out-of-pocket expenses, and the silver level has higher out-of-pocket expenses.

For 2009, you will receive the gold out-of-pocket expense level for your medical plan. In 2009, you will need to take a wellness assessment by Jan. 31, 2009, and complete an individual action plan by June 30, 2009, if you want to receive the gold out-of-pocket expense level for your medical benefits in 2010. If you cover a spouse/domestic partner under your medical benefits, your spouse/domestic partner will also need to take the wellness assessment by Jan. 31, 2009, and complete an individual action plan by June 30, 2009, if you want your family to receive the gold out-of-pocket expense level for your medical benefits in 2010. Please read your contract for additional details about this program.

If you are covered under the Deputy Sheriff Plan, two separate companies process your claims. You receive a medical card from Aetna to use for all medical claims (physician visits, hospital, lab work, etc.) and a prescription card from Express Scripts to use for all outpatient, retail pharmacy and mail-order prescription drug claims. With Group Health, you receive one card for both medical and prescription drug claims.

Deputy Sheriff Plan

Plan Feature	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers. Reimbursement for out-of-network medical services is based on reasonable and customary (R&C) rates, and reimbursement for out-of-network prescription drug services is based on the rates Express Scripts pays its network pharmacies. You pay amounts in excess of these rates.	

Plan Feature	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Annual deductible	$50/person; $150/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**	$200/person; $600/family Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year's deductible. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**
Copays	Applicable only to emergency room care and prescription drugs	
After the deductible/copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 90% (You pay 10% coinsurance) Out-of-network: 70% (You pay 30% coinsurance) 100% of network rate after applicable copays for prescription drug claims (deductible doesn't apply)	Network: 80% (You pay 20% coinsurance) Out-of-network: 60% (You pay 40% coinsurance) 100% of network rate after applicable copays for prescription drug claims (deductible doesn't apply)
Annual out-of-pocket maximum	Network: $375/person or $1,125/family, plus deductible Out-of-network: $1,600/person or $3,200/family, plus deductible Doesn't apply to prescriptions	Network: $800/person or $1,600/family, plus deductible Out-of-network: $1,800/ person or $3,600/ family, plus deductible Doesn't apply to prescriptions
After you reach the out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	Network: 100% Out-of-network: 100% of R&C charges	
Lifetime maximum	$2,000,000	

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Allergy testing and treatment (including injections separate from office visit)	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Alternative care (including medically necessary acupuncture, hypnotherapy and massage therapy)	Network: 90% Out-of-network: 70% Massage therapy must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)	Network: 80% Out-of-network: 60% Massage therapy must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)
Ambulance services	Network: 90% Out-of-network: 90%	Network: 80% Out-of-network: 80%
Chemical dependency treatment (requires preauthorization)	Network: 100% Out-of-network: 70% Up to $15,000 in 24 consecutive months for combined network and out-of-network services (maximum subject to annual adjustment)	Network: 80% Out-of-network: 60% Up to $15,000 in 24 consecutive months for combined network and out-of-network services (maximum subject to annual adjustment)

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	Network: 90% Out-of-network: 70% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 80% Out-of-network: 60% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders
Diabetes care training	Network: 90% when prescribed by your physician Out-of-network: 70% when prescribed by your physician	Network: 80% when prescribed by your physician Out-of-network: 60% when prescribed by your physician
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	
Durable medical equipment, prosthetics and orthopedic appliances	Network: 90% Out-of-network: 70% Preauthorization required for expense of $1,000 or more	Network: 80% Out-of-network: 60% Preauthorization required for expense of $1,000 or more
Emergency room care (Also see "Urgent Care")	Emergency care, network and out-of-network: 90% after $25 copay/visit (waived if admitted) Non-emergency care, network and out-of-network: 90% after $25 copay/visit	Emergency care, network and out-of-network: 80% after $50 copay/visit (waived if admitted) Non-emergency care, network and out-of-network: 80% after $50 copay/visit
Family planning	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Growth hormones	Network: 90% when preauthorized Out-of-network: 70% when preauthorized May also be covered under the prescription drug benefit	Network: 80% when preauthorized Out-of-network: 60% when preauthorized May also be covered under the prescription drug benefit
Hearing aids	100%, up to $500 in 36 months for combined network and out-of-network services Deductible doesn't apply.	
Hearing exam	Network: 100%, no deductible (included as part of routine physical exam) Out-of-network: 70%, after deductible (included as part of routine physical exam)	Network: 100%, no deductible (included as part of routine physical exam) Out-of-network: 60%, after deductible (included as part of routine physical exam)
Home health care	100% when preauthorized, up to 130 visits/year for combined network and out-of-network services	
Hospice care	100% when preauthorized 12-month lifetime maximum 120-hour maximum for respite care in any 3-month period 12-month maximum for bereavement services	
Hospital care (both inpatient and outpatient, including outpatient surgery)	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Infertility	Network: 90% Out-of-network: 70% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services	Network: 80% Out-of-network: 60% Limited to specific services and $25,000 lifetime maximum for combined network and out-of-network services
Injury to teeth	Network: 90% Out-of-network: 70% Up to $600/accident for combined network and out-of-network services	Network: 80% Out-of-network: 60% Up to $600/accident for combined network and out-of-network services
Inpatient care alternatives	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
Jaw abnormalities, or malocclusions (covered when medically necessary)	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
Lab, X-ray and other diagnostic testing	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Maternity care	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)	Network: 90% Out-of-network: 70% *For inpatient care:* Up to 30 days/year for combined network and out-of-network services *For outpatient care:* Up to 52 visits/year for combined network and out-of-network services	Network: 80% Out-of-network: 60% *For inpatient care:* Up to 30 days/year for combined network and out-of-network services *For outpatient care:* Up to 52 visits/year for combined network and out-of-network services
Naturopathy	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Neurodevelopmental therapy for covered dependents age 6 and under	Network: 90% when preauthorized Out-of-network: 70% when preauthorized Up to $2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Up to $2,000/year for combined network and out-of-network services
Obesity surgery or other procedures, treatment or services, such as gastric intestinal bypass surgery	Network: 90% when preauthorized and medically necessary Out-of-network: 70% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program is required before preauthorization.	Network: 80% when preauthorized and medically necessary Out-of-network: 60% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program is required before preauthorization.
Out-of-area coverage—for example, while traveling or for your covered children away at school	Same coverage as when home, through Aetna and Express Scripts national provider networks	

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Phenylketonuria (PKU) formula	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Physician and other medical/surgical services	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $7 copay Preferred brand: 100% after $12 copay ($20 if generic is available; but if you're unable to take it for medical reasons, the $12 copay applies) Non-preferred brand: 100% after $25 copay ($30 if generic is available; but if you're unable to take it for medical reasons, the $25 copay applies) Prescriptions filled at out-of-network pharmacies are reimbursed at the rate Express Scripts pays to network pharmacies, less your copay.	Generic: 100% after $10 copay Preferred brand: 100% after $15 copay ($20 if generic is available; but if you're unable to take it for medical reasons, the $15 copay applies) Non-preferred brand: 100% after $25 copay ($30 if generic is available; but if you're unable to take it for medical reasons, the $25 copay applies) Prescriptions filled at out-of-network pharmacies are reimbursed at the rate Express Scripts pays to network pharmacies, less your copay.
Prescription drugs—Up to a 90-day supply through mail-order network only	Generic: 100% after $14 copay Preferred brand: 100% after $24 copay ($40 if generic is available; but if you're unable to take it for medical reasons, the $24 copay applies) Non-preferred brand: 100% after $50 copay ($60 if generic is available; but if you're unable to take it for medical reasons, the $50 copay applies)	Generic: 100% after $20 copay Preferred brand: 100% after $30 copay ($40 if generic is available; but if you're unable to take it for medical reasons, the $30 copay applies) Non-preferred brand: 100% after $50 copay ($60 if generic is available; but if you're unable to take it for medical reasons, the $50 copay applies)
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	Network: 100% Out-of-network: 70% Deductible doesn't apply.	Network: 100% Out-of-network: 60% Deductible doesn't apply.
Radiation therapy, chemotherapy and respiratory therapy	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Rehabilitative services—Inpatient and outpatient	Network: 90% Out-of-network: 70% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)	Network: 80% Out-of-network: 60% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)
Skilled nursing facility	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Smoking cessation	100%, no deductible Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.	
Temporomandibular joint (TMJ) disorders	Network: 90% when preauthorized Out-of-network: 70% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to $2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to $2,000/year for combined network and out-of-network services
Transplants (certain services only)	Network: 100% when preauthorized Out-of-network: 70% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered. No lifetime maximum	Network: 100% when preauthorized Out-of-network: 70% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered. No lifetime maximum
Urgent care (ear infections, high fevers, minor burns, etc.)	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%

Group Health

Plan Feature	Group Health Gold	Group Health Silver
Provider choice	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.	
Annual deductible	None	
Copay, unless otherwise indicated	You pay $7	You pay $20
After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 100% Out-of-network: Limited emergency/out-of-area care	
Annual out-of-pocket maximum	Network: $1,000/person or $2,000/family Out-of-network: Limited emergency/out-of-area care Pharmacy copays do not apply to annual out-of-pocket maximum.	Network: $1,500/person or $3,000/family Out-of-network: Limited emergency/out-of-area care Pharmacy copays do not apply to annual out-of-pocket maximum.
After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	Network only: 100%	
Lifetime maximum	No limit	

Covered Expenses	Group Health Gold	Group Health Silver
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	Self-referrals to a network provider: $7 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: $20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.
Ambulance services	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)	
Chemical dependency treatment (requires preauthorization)	*For inpatient care:* 100% *For outpatient care:* 100% after $7 copay/visit Up to $14,500 in 24 consecutive months (maximum subject to annual adjustment)	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/visit Up to $14,500 in 24 consecutive months (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	100% after $7 copay/visit	100% after $20 copay/visit
Diabetes care training	100% after $7 copay/visit	100% after $20 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs

Covered Expenses	Group Health Gold	Group Health Silver
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	80% when preauthorized
Emergency room care	Network: 100% after $75 copay/visit ($75 copay is waived if admitted) Out-of-network: 100% of reasonable and customary expenses after $125 copay/visit ($125 copay is waived if admitted) **Non-emergency care is not covered.**	Network: 100% after $100 copay/visit ($100 copay is waived if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived if admitted) **Non-emergency care is not covered.**
Family planning	100% after $7 copay/visit **Infertility treatment is not covered.**	100% after $20 copay/visit **Infertility treatment is not covered.**
Growth hormones	100%, covered under prescription drugs	
Hearing aids	Not covered	
Hearing exam (routine)	100% after $7 copay	100% after $20 copay
Home health care	100%	
Hospice care	100% when preauthorized Certain limits apply; call plan for details.	
Hospital care	Inpatient: 100% Outpatient surgery: 100% after $7 copay/surgery	Inpatient: 100% Outpatient surgery: 100% after $20 copay/surgery
Infertility services	Not covered	
Inpatient care alternatives	100% when preauthorized	
Lab, X-ray and other diagnostic testing	100%	
Maternity care	*For delivery and related hospital care:* 100% *For prenatal and postpartum care:* 100% after $7 copay/visit	*For delivery and related hospital care:* 100% *For prenatal and postpartum care:* 100% after $20 copay/visit
Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)	*For inpatient care:* 100%, up to 12 days/year *For outpatient care:* 100% after $7 copay/individual, family, couple or group session, up to 20 visits/year	*For inpatient care:* 100%, up to 12 days/year *For outpatient care:* 100% after $20 copay/individual, family, couple or group session, up to 20 visits/year
Neurodevelopmental therapy for covered dependents age 6 and under	*For inpatient care:* 100%, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $7 copay/visit, up to 60 visits/year (combined with rehabilitative services)	*For inpatient care:* 100%, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.	
Phenylketonuria (PKU) formula	100%	

Covered Expenses	Group Health Gold	Group Health Silver
Physician and other medical/surgical services	*For inpatient care:* 100% after $7 copay *For outpatient care:* 100% after $7 copay/office visit	*For inpatient care:* 100% after $20 copay *For outpatient care:* 100% after $20 copay/office visit
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $5 copay Preferred brand: 100% after $5 copay Non-preferred brand: Not covered Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.	Generic: 100% after $10 copay Preferred brand: 100% after $15 copay Non-preferred brand: Not covered Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.
Prescription drug—Up to a 90-day supply through mail-order network only	Generic: 100% after $10 copay Preferred brand: 100% after $10 copay Non-preferred brand: Not covered	Generic: 100% after $20 copay Preferred brand: 100% after $30 copay Non-preferred brand: Not covered
Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)	100% after $7 copay/visit (according to well-child/adult preventive schedule)	100% after $20 copay/visit (according to well-child/adult preventive schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after $7 copay/visit	100% after $20 copay/visit
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.	100% depending on services provided; copays may apply	100% depending on services provided; copays may apply
Rehabilitative services—Inpatient and outpatient	*For inpatient care:* 100%, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $7 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	*For inpatient care:* 100%, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility	
Smoking cessation	100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free & Clear® Quit for Life™ Program, when prescribed by Group Health PCP No annual or lifetime limit	
Sterilization (tubal ligation or vasectomy)	100% after $7 copay	100% after $20 copay
Temporomandibular joint (TMJ) disorders	*For inpatient care:* 100% *For outpatient care:* 100% after $7 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum

Covered Expenses	Group Health Gold	Group Health Silver
Transplants (certain services only)	Inpatient: 100% Outpatient: 100% after $7 copay Medical coverage must have been continuous for more than 12 months under this plan before a transplant will be covered.	Inpatient: 100% Outpatient: 100% after $20 copay Medical coverage must have been continuous for more than 12 months under this plan before a transplant will be covered.
Urgent care (ear infections, high fevers, minor burns)	100% after $7 copay/visit	100% after $20 copay/visit
Vision exams	100% after $7 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after $20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)

Dental plan

Dental coverage is provided by Washington Dental Service. You can use any dentist you want, but the benefits are generally higher (your out-of-pocket expenses are less) and the dentist automatically files your claim if you see a WDS dentist.

WDS increases your payment levels through an incentive program as long as you see your dentist each year:

- For diagnostic and preventive services, basic services and restorative services, the payment level starts at 70% and increases 10% in January of each year until you reach 100% (if you don't see the dentist during the calendar year, your payment level is reduced to the next lower payment level, but never below 70%).

If you're a newly hired employee, coverage begins at the 70% incentive level; levels "earned" under another group plan don't apply to the county plan. However, incentive levels are adjusted based on previous participation in the county plan if you're a:

- Recalled or reinstated employee
- Rehired employee who's continued county coverage uninterrupted under COBRA between previous county employment and rehire (if county coverage has been interrupted, new hire incentive levels apply).

Washington Dental Service	
Annual deductible	None
Annual maximum benefit (doesn't apply to orthodontic or orthognathic services)	$2,500/person
Covered Expenses	**Plan Pays**
Diagnostic and preventive services (1 exam and cleaning every 6 months, complete x-rays every 3 years, supplemental bitewing X-rays every 6 months)	70%-100% based on your incentive level; see dental booklet for details
Basic services (extractions, fillings, periodontics, root canals, stainless steel crowns)	70%-100% based on your incentive level; see dental booklet for details
Major services – restorative (crowns, fixed bridges, onlays)	70%-100% based on your incentive level; see dental booklet for details
Major services – prosthodontics (for example, dentures)	70% (incentive levels don't apply)
Orthodontic services - adults and children	60%, up to a $2,500 lifetime benefit maximum (incentive levels don't apply; benefit doesn't apply to the annual maximum benefit)
Orthognathic surgery	70% up to a $5,000 lifetime maximum benefit
Accidental injury	100% for covered expenses incurred within 180 days of accident

Vision plan

Vision coverage is provided by Vision Service Plan. You can use any eye care provider you want, but the benefits are generally higher (your out-of-pocket expenses are less) and the provider automatically files your claim if you see a VSP provider. (Group Health provides routine vision exams under its medical plan, but none of the other vision benefits listed below; VSP providers may not accept a Group Health prescription for lenses.)

Vision Plan		
Covered Expenses	**If you see a VSP provider, you pay a $10 copay and the plan pays the amount listed below**	**If you see a non-VSP provider, you pay the bill in full and the plan reimburses you the amounts listed below, minus a $10 copay**
Exam (once every 12 months)	100%	Up to $40
Eyeglass lenses (one pair every 12 months)		
• Single vision	100%	Up to $40
• Lined bifocal	100%	Up to $60
• Lined trifocal	100%	Up to $80
• Progressive lenses	100%	Up to trifocal allowance of $80
• Lenticular	100%	Up to $125
• Polycarbonate lenses for children	100%	Not covered
• Anti-reflective coating	100%	Not covered
• Color/mirror coating	100%	Not covered

Vision Plan		
• Scratch coating	100%	Not covered
• Tints/photochromic lenses	100%	Up to $5
• UV lenses	100%	Not covered
Eyeglass frames (once every 24 months)	Up to $130; if you choose a frame that costs more than the VSP allowable amount, you'll receive 20% off your out-of-pocket cost	Up to $45
Contact lenses (once every 12 months in place of eyeglass lenses and frames)		
• Elective (Providers may bill you for contact lenses separately or they may include the lenses, fittings and follow-up fees in a single bill; all contact lens fees apply to the $105 maximum paid by the plan)	Up to $105	Up to $105
• Medically necessary	100% (Preauthorization required)	Up to $210 (Preauthorization required)
• Low-vision benefit	75% up to $1,000 (Preauthorization required)	75% up to $1,000 (Preauthorization required)

Life insurance

You automatically receive county-paid basic life insurance. If you die for any reason, your beneficiaries receive $6,000. The eligible family members you enroll also automatically receive county-paid basic life insurance. If your spouse/domestic partner or child (14 days or older) dies, you receive $1,000.

You may purchase additional/ supplemental life insurance for yourself in an amount equal to your base annual salary, less $6,000. If you die, your beneficiaries receive the supplemental life amount in addition to your county-paid basic life insurance.

The cost for supplemental life insurance in 2009 is $ 0.327/$1,000 per month. If your base annual salary is $50,000, you're eligible to purchase $50,000 - $6,000 = $44,000 of supplemental life insurance. The cost is $.327 x 44 = $14.39 per month.

If you decline supplemental life for yourself now, or discontinue or reduce it later (you may discontinue or reduce it anytime), you may add or increase it again:

- During Open Enrollment
- Between Open Enrollments when certain qualifying events occur – for example, you marry/establish a new domestic partnership or a new dependent child becomes eligible.

To add supplemental life when a qualifying event occurs, submit a Life/AD&D Change form to Benefits, Payroll and Retirement Operations within 30 days of the qualifying event. No evidence of insurability is required if you elect supplemental life when you first enroll or when

a qualifying event occurs. However, evidence of insurability is required if you add it during Open Enrollment.

Life insurance is provided through Aetna and is portable. When you end employment with the county for reasons other than disability, you may continue to pay Aetna directly for the basic and supplemental coverage you had on your last day of employment until you reach age 99. The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

If you end employment with the county for reasons other than disability and continue supplemental life insurance coverage under the portability option, you may pay to continue coverage for a spouse/domestic partner until he/she is 99 and a child until he/she is 19 (25 if solely dependent on you for support). The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

Accidental death and dismemberment insurance

You automatically receive county-paid basic accidental death and dismemberment (AD&D) insurance. If you die in a covered accident, the beneficiaries you designate receive $6,000 in addition to your basic life insurance benefit. If you are dismembered or paralyzed, you receive an amount that depends on the type of loss. (AD&D insurance isn't available to family members.) Your AD&D benefit includes some additional benefits, like emergency help while traveling, from Worldwide Assistance.

Naming beneficiaries

Whether you elect supplemental coverage or not, you receive county-paid basic life and AD&D insurance. Therefore, you need to designate beneficiaries – the people you want to receive these benefits in the event of your death. To do so, complete a Aetna Life Insurance Company Designation of Beneficiary form and the CIGNA Group Insurance Beneficiary Designation Form. Mail the forms directly to the address found on each form, which are available at www.kingcounty.gov/employees/benefits. Be sure to keep copies for your records.

Provide complete information so your beneficiaries can be located if you die. You may list only the last four digits of beneficiary Social Security numbers if you choose, but complete Social Security numbers facilitate benefit payment.

The forms allow you to designate primary and contingent beneficiaries. If your primary beneficiaries aren't alive at the time of your death, contingent beneficiaries receive your benefit. If you name multiple beneficiaries (primary or contingent), assign the share each beneficiary receives. Shares for all primary beneficiaries need to total 100% and shares for all contingent beneficiaries need to total 100%.

For example, you might name your spouse as primary and your two children as contingents. You'd assign your spouse 100% of your insurance benefit and could assign each child 50% of the benefit or one child 60% and the other 40% – whatever combination of shares totals

100%. If your spouse isn't alive to receive the benefit in the event of your death, your contingent children receive it according to the shares you assign. (If you're married and don't list your spouse as primary with at least 50% of your benefit, your spouse should sign the spouse waiver section of the form.)

If you don't designate beneficiaries and die, the State of Washington determines beneficiaries for you:

- For life and AD&D insurance, benefits are paid to your spouse, your children, your parents or your siblings, in that order. If none of them survives you, benefits are paid to your estate.
- For long-term disability (there's a death benefit if you die while on long-term disability), the survivor benefit is paid to your spouse or eligible children, in that order. If none of them survives you, benefits are paid to your estate.

Adding dependents

The following family members are eligible for coverage if you enroll them:

- Your spouse/domestic partner
- Your unmarried children or the unmarried children of your spouse/domestic partner if they are under age 25 and chiefly dependent on you for support and maintenance (generally, that means you may claim them on your federal tax return); they may be your:
  - Biological children
  - Adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption)
  - Stepchildren
  - Legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order; attach appropriate documentation).

If you don't add eligible dependents when your first enroll or during open enrollment, you must wait until the next open enrollment to add them, except for certain qualifying life events such as:

- Birth or placement for adoption of a child
- Placement of a legal ward
- Marriage/establishment of a domestic partnership
- A Qualified Medical Child Support Order
- A significant change in your spouse/domestic partner's employer-sponsored coverage.

In general, when a qualifying life event occurs, you must submit Add Dependent and Life/AD&D Change forms to Benefits, Payroll and Retirement Operations within 30 days of the event.

Tax implications for domestic partner health coverage

There is no cost to cover family members, but when you cover a domestic partner (DP) and his/her children for health benefits (medical/vision and dental) the IRS taxes you on the value of the coverage. This value is added to the salary shown on your paycheck (and W-2 at the end of the year), federal income and Social Security (FICA) taxes are withheld on the higher salary amount, then the value is subtracted from your salary.

Monthly Taxable Value of Health Plans	DP Only	DP's Children	DP + DP's Children
	2009	2009	2009
Deputy Sheriff Plan Gold + Dental + Vision	$ 607.70	$ 359.34	$ 967.04
Group Health + Dental + Vision	$ 539.13	$ 509.00	$1,048.15

Flexible spending accounts

Flexible spending accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA you don't pay federal or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

- Health care FSAs allow you to set aside pretax dollars to pay for certain expenses not covered by your medical/vision and dental plans (for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan).
- Dependent care FSAs allow you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

Leaving employment

If you leave employment, you may self-pay to continue county-paid coverage; details are provided in "Deputy Sheriff: Your King County Benefits" and the Exit Guide available at www.metrokc.gov/employees/benefits. Your monthly self-pay rates for health coverage are based on what the county pays to provide the same coverage to you as an active employee. Here, for reference, are the monthly self-pay rates for 2009 and 2008.

Health Plan	You	Spouse/Domestic Partner	Dependent Child(ren)
Deputy Sheriff Plan Gold	*2009* ► $ 600.27 *2008* ► N/A	*2009* ► $ 550.02 *2008* ► N/A	*2009* ► $ 289.10 *2008* ► N/A
Group Health Gold	*2009* ► $ 422.45 *2008* ► $ 413.17	*2009* ► $ 480.08 *2008* ► $ 469.54	*2009* ► $ 441.75 *2008* ► $ 432.04
Washington Dental Service	*2009* ► $ 68.89 *2008* ► $ 63.19	*2009* ► $ 62.29 *2008* ► $ 56.59	*2009* ► $ 70.72 *2008* ► $ 74.00
Vision Service Plan	*2009* ► $ 9.07 *2008* ► N/A	*2009* ► $ 7.54 *2008* ► N/A	*2009* ► $ 6.71 *2008* ► N/A

Resource guide

For Questions About ...	Contact ...
AD&D Insurance ▪ Conversion when you leave employment ▪ Secure travel benefits ▪ For claims, contact Benefits, Payroll and Retirement Operations	CIGNA Group Insurance CIGNA Customer Service Center, P.O. Box 20310, Lehigh Valley, PA 18002-0310 Phone 1-800-557-7975 (conversion) ▪ 1-800-362-4462 (claims) Worldwide Assistance Services Inc. (secure travel benefits) Phone 1-888-226-4567 (US/Canada) ▪ 1-800-336-2485 (TTY) Fax 202-331-1528 E-mail cigna@worldwideassistance.com
Benefits – General ▪ Eligibility ▪ Open enrollment and making changes ▪ Flexible spending account enrollment ▪ Life, AD&D and LTD insurance plan details ▪ Alternate formats	Benefits, Payroll and Retirement Operations The Chinook Building CNK-ES-0240, 401 Fifth Ave., Seattle WA 98104-2333 Phone 206-684-1556 ▪ 1-800-325-6165 x41556 (outside local calling area) Fax 206-296-7700 E-mail kc.benefits@kingcounty.gov Web www.kingcounty.gov/employees/benefits
Dental ▪ Providers ▪ Claims and appeals ▪ Other plan details	Washington Dental Service (WDS) PO Box 75983, Seattle WA 98175-0983 Phone 1-866-229-4102 E-mail cservice@deltadentalwa.com Web www.deltadentalwa.com
Flexible Spending Accounts (FSAs) ▪ Account balances ▪ Reimbursement ▪ Other plan details	FBMC PO Box 1878, Tallahassee, FL 32302-1878 Phone 1-866-879-8689 (Monday-Friday, 4 a.m.-7 p.m. Pacific) Fax 1-866-440-7145 Web www.myFBMC.com
Life Insurance ▪ Conversion or portability option when you leave employment ▪ Evidence of Insurability (EOI) ▪ For claims, contact Benefits, Payroll and Retirement Operations	Aetna Life Insurance Company PO Box 14547, Lexington, KY 40512-4547 Phone 1-800-826-7448 (conversion/portability) ▪ 1-800-523-5065 (claims/EOI) Customer service phone 1-800-584-2983 ▪ 1-800-803-5934 (fax)

For Questions About ...	Contact ...
Medical – General ▪ Providers (doctors, hospitals, etc.) ▪ Claims and appeals ▪ Identification cards ▪ Preauthorization ▪ Other plan details (covered expenses, limitations, exclusions)	Deputy Sheriff Plan – Aetna, Inc. PO Box 14079, Lexington KY 40512-4079 Phone 1-800-654-3250 (medical) ▪ 1-888-632-3862 (medical preauthorization) E-mail kingcare@aetna.com Web www.kingcare.com Medical Claims – Aetna Inc. PO Box 14079, Lexington KY 40512-4079 Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 1-888-901-4636 E-mail info@ghc.org Web www.ghc.org
Medical – Prescriptions ▪ Drug formulary (covered drugs, including generic, preferred brand and non-preferred brand) ▪ Pharmacies ▪ Mail order service ▪ Filing claims and appeals ▪ Identification cards (KingCare℠ members only; Group Health members use medical plan card for prescriptions)	Deputy Sheriff Plan – Express Scripts, Inc. Member Reimbursements, PO Box 66583, St. Louis, MO 63166 Phone 1-800-332-2213 ▪ 1-800-899-2114 (TTY) Web www.express-scripts.com Group Health Cooperative (for mail-order prescriptions) Phone 1-800-245-7979 Web www.MyGroupHealth.com
Vision ▪ Providers ▪ Claims and appeals ▪ Other plan details	Vision Service Plan PO Box 997100, Sacramento CA 95899-7100 Phone 1-800-877-7195 ▪ 1-800-428-4833 (TTY) Web www.vsp.com